TEXAS
Health and Human Services

Form 2960 Attachment A
July 2018-E

General Residential Operations
Documentation Required at Application

Use this attachment to help evaluate whether the required documentation is present with an application.

Directions: This attachment is a guide for applicants and Residential Child Care Licensing (RCCL) staff when reviewing documents presented with an application for licensure. If there are any questions, email Rcclstan@hhsc.state.tx.us.

Documentation that Must Be Submitted to Licensing to Apply for a License	
Document	**Form Number**
Application for a License to Operate a Residential Child Care Facility, or child-placing agency	2960
Floor Plan of the building and surrounding space to be used, showing the dimensions and the purpose of all rooms.	NA
Child Care Licensing Request for Background Check	2971
Controlling Person – Child Care Licensing	2760
Personal History Statement, for each applicant that is sole proprietor or partner unless you are also a licensed administrator.	2982
Proof the for-profit corporation or limited liability company is not delinquent in paying the franchise tax. For information on the franchise tax, see Texas Administrative Code (TAC) §745.245.	NA
Verification of Liability Insurance, or documentation that you are unable to obtain liability insurance and a copy of the written notice informing the parents that there is no insurance. See TAC §745.249 and §745.251.	2962
Residential Child Care License Fee Schedule (with payment sent to Austin and a copy submitted with the application).	3011

Policies, Procedures and Documentation Required by the Minimum Standards Must Be Submitted with Application,* as Applicable	
Operation plan	TAC §748.101(A)-(B)
Fiscal plan and requirements	§748.101(2)(A)-(D); §748.161
Floor plan and emergency evacuation/relocation plan	§748.101(3)-(4)
General record requirements	§§748.103; 748.341; 748.343; 748.345; 748.347;
Personnel policies and procedures	§§748.105; Subchapter E, Divisions 2, 3, 4;748.1009; 748.1339; 748.1345; 745.4151
Conflict of interest policies	§748.107
Admission policies	§§748.1203(a);748.1211(b)(2);748.1825; 748.109
Child-care policies	§§748.111; 748.1107(a)(1); 748.1305; 748.1481(b)(1); 748.1941(1)
Emergency behavior intervention policies	§§748.113; 748.1823; 748.2451; 748.2751(a)(1); 748.2753(a)(1); 748.2755(a)(1)

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Policies, Procedures and Documentation Required by the Minimum Standards Must Be Submitted with Application,* as Applicable	
Discipline policies	§748.115
Transitional living program policies	§748.117
Volunteer policies	§748.119
Abuse neglect policies	§748.121
Vaccine preventable diseases policy	§748.123
Tobacco use policies	§748.1661
Recreational plan, including weapons/firearms, etc.	§§748.3931(3); 748.3701(b)

*Subchapters B-R - (§§748.41-748.4111) are applicable for all GRO and RTCs;
*Subchapter S - (§§748.4201-748.4269) is applicable if the operation offers emergency care services;
*Subchapter T - (§§748.4301-748.4397) is applicable if the operation offers an assessments services program;
*Subchapter U - (§§748.4401-748.4473) is applicable if the operation offers therapeutic camp services; and
*Subchapter V - (§§748.4501-748-4767) is applicable if the operation offers trafficking victim services.

TEXAS
Health and Human Services

Form 2960
April 2019-E

Application for a License to Operate a Residential Child Care Facility

Use this form to apply for a license to operate a residential child care facility, including a child-placing agency.

Directions: After completing this form, mail it and any other materials requested to your nearest Licensing office. For information on local Licensing offices, see: https://hhs.texas.gov/services/safety/child-care/contact-child-care-licensing.

Part I – About Your Operation

Name of Operation				Area Code and Phone No.	
CHS Stanford House Shelter				[redacted]	
Address [redacted]	Apartment No.	City Los Fresnos	County [redacted]	State Texas	ZIP Code [redacted]
Mailing Address (if different) [redacted]	Apartment No.	City Los Fresnos	County [redacted]	State Texas	ZIP Code [redacted]

Type of Governing Body:

○ Sole Proprietorship ○ Association ◉ Corporation ○ Nonprofit Association ○ Nonprofit Corporation ○ Partnership
○ Limited Partnership ○ Limited Liability Partnership ○ Political Subdivision ○ Limited Liability Company
○ State Operated ○ Nonprofit Corporation with Religious Affiliation ○ Nonprofit Association with Religious Affiliation

Part II – Applicant Information

Section 1 – Complete this section if your type of governing body is a **Sole proprietorship or Partnership** (General, Limited Partnership, or Limited Liability Partnership.

If you have **more than two partners**, attach the information requested here for each.

Name of Entity (Required for a Limited Partnership or Limited Liability Partnership.)					
Name of Sole Proprietor or Partner		Area Code and Phone No.			
Street Address or P.O. Box	Apartment No.	City	County	State	ZIP Code
Name of Second Partner		Area Code and Phone No.			
Street Address or P.O. Box	Apartment No.	City	County	State	ZIP Code

☐ Check here if you are (or a partner is) a military member, military spouse, military veteran or veteran spouse. This applies only if your governing body is a sole proprietorship or partnership.

Section 2

Complete this section if your type of governing body is an association, corporation, nonprofit association, nonprofit corporation, political subdivision, nonprofit corporation with religious affiliation, nonprofit association with religious affiliation, limited liability company, or state operated.

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Name of Organization or Governing Body	Area Code and Phone No.				
Comprehensive Health Services, LLC	(321) 868-8500				
Street Address or P.O. Box	Apartment No.	City	County	State	ZIP Code
8600 Astronaut Blvd.		Cape Caneveral	Brevard	Florida	32920

Part III – Child Population

◉ Boys ◉ Girls Age Range: 0 To: 17 Expected Number of Children: 64

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Part IV – Operation Type and Services

Operation Type (Select one type of operation.)	Programmatic Services (Select all that apply for your type of operation.)	Treatment Services (Select all that apply for your type of operation.)
○ General Residential Operation operating as a Residential Treatment Center	☐ Child Care Services ☐ Emergency Care Services ☐ Respite Child Care Services ☐ Transitional Living Program ☐ Assessment Services ☐ Therapeutic Camp Services	☐ Emotional Disorders ☐ Intellectual Disability ☐ Autism Spectrum Disorder ☐ Primary Medical Needs
○ General Residential Operation offering Emergency Care Services **only**	☐ Child Care Services ☐ Emergency Care Services ☐ Respite Child Care Services ☐ Transitional Living Program ☐ Assessment Services	(Select one of the following treatment services only if your Emergency Care Services program is limited to a specific target population.) ☐ Emotional Disorders ☐ Intellectual Disability ☐ Autism Spectrum Disorder ☐ Primary Medical Needs
◉ General Residential Operation offering Child Care Services **only**	◉ Child Care Services ☐ Transitional Living Program	(Treatment services are **not** permitted for operations that provide Child Care Services **only**.)
○ General Residential Operation offering multiple services	☐ Child Care Services ☐ Emergency Care Services ☐ Respite Child Care Services ☐ Transitional Living Program ☐ Assessment Services ☐ Therapeutic Camp Services	☐ Emotional Disorders ☐ Intellectual Disability ☐ Autism Spectrum Disorder ☐ Primary Medical Needs
○ Child-Placing Agency ☐ Foster Care ☐ Adoption	☐ Child Care Services ☐ Transitional Living Program ☐ Assessment Services ☐ Respite Child Care Services	☐ Emotional Disorders ☐ Intellectual Disability ☐ Autism Spectrum Disorder ☐ Primary Medical Needs

Part V – Permit History

Do you (the applicant) have either a permit to provide any other type of child care or child-placing services, or a pending application to provide such services?

◉Yes	○No	If yes, specify the name of the operation and type of permit:	GRO-Norma Linda Shelter,San Benito Shelter

Have you (the applicant) ever been denied a permit to provide child care or child-placing services?.....	○Yes	◉No	
If yes, provide the date of denial:		Type of operation denied:	
Operation's address (Street, City, State, and ZIP Code)		County	
What was the reason for the denial?			
Have you (the applicant) ever had a permit for child care or child-placing services revoked?	○Yes	◉No	
If yes, provide the date of revocation:		Type of operation revoked:	
Operation's address (Street, City, State, and ZIP Code)		County	
If the revocation occurred in another state, list the name and address of the regulatory body that issued the revocation.			
What is the reason for the revocation?			
Have you (the applicant) ever been prohibited or barred from operating any other type of child care operation?	○Yes	◉No	
If yes, provide the date of the prohibition or bar:		Type of operation barred:	
Operation's address (Street, City, State, and ZIP Code):		County:	
If the bar occurred in another state, list the name and address of the regulatory body that issued the bar:			
What was the reason for the prohibition or bar?			
Have you (the applicant) ever been a controlling person at an operation?.....	○Yes	◉No	
If yes, provide the dates:	Was the operation's permit revoked?	○Yes	○No
If so, provide the date of revocation.....			
Name of the Operation			
Operation's address (Street, City, State, and ZIP Code)		County	

Part VI – Additional Information for Publication on the Child Care Licensing (CCL) Website

Web Address http:// www.chsmedical.com

Email Address
krigdon@chsmedical.com or maguilar02@chsmedical.com

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Name of Administrator or Executive Director: ..... Melissa Aguilar, Administrator

Behavior Interventions: (Check all that apply):

☐ Seclusion ☒ Personal Restraints ☐ Mechanical Restraints ☐ Emergency Medication

Part VI – Additional Information for Publication on the Child Care Licensing (CCL) Website

Devices: (Check all that apply): ☐ Protective Devices ☐ Supportive Devices

Special Services Provided: (Check all that apply):

☐ Young Adult Care ☐ Interstate Compact on the Placement of Children (for children from another state)

☐ International Adoptions ☐ Physically Challenged (provides accommodations for children with physical disabilities)

☐ Human Trafficking Services

Part VII – For Child-Placing Agencies

Attach a complete list of your offices and agency homes, and indicate which of your offices regulates each home.

Part VIII – Designating a Governing Body

Name of Chief Executive Officer or Head of the Governing Body: Keith Rigdon			Area Code and Phone No.: (321) 868-8500	
Mailing Address: 8600 Astronaut Blvd.	City: Cape Canaveral	County: Brevard	State: Florida	ZIP Code: 32920
Name of Designated Governing Body: Melissa Aguilar			Area Code and Phone No.: (956) 233-0812	
Mailing Address: 31201 State Highway 100	City: Los Fresnos	County: Cameron	State: Texas	ZIP Code: 78566

I hereby designate the person stated above as the official representative (designee) to speak for and act on our organization's behalf.

- I understand that, as the permit holder, the governing body is ultimately responsible for maintaining compliance with the minimum standards and other child care licensing law.

- I understand that all waivers and variances must be requested and signed by me or by the designee.

- I understand that the governing body must notify Licensing anytime there is a change in the governing body's designee.

- I understand that Licensing provides the governing body and all controlling persons in the operation with documents showing the operation's compliance or deficiencies and any remedial actions that Licensing takes against the operation.

Authorized Signature

Signature of the Chief Executive Officer or Head of the Governing Body or Each Partner	Signer's Title: Vice President, HIS	Date Signed 7/11/2019

Part IX – Certification and Signature

I certify that the information provided here contains no willful misrepresentation or falsification and that it is true and complete to the best of my knowledge and belief. I understand that any willful misrepresentation is cause for immediate denial of the application or later denial or revocation of the license. The documentation to complete this application is attached (see the checklist provided below). I understand that this application will be returned if the attached documentation is incomplete or does not conform to applicable laws. If a license is granted, there will be no racial discrimination in the admission or care of children.

Signature of ~~Applicant, Designee,~~ or Head of the Governing Body

Date Signed 7/11/2019

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Part IX – Certification and Signature

- [x] Floor plan of the building and surrounding space to be used (with indoor dimensions and the purpose of all rooms provided). I, if applicable, specify where the children and caregivers will sleep.
- [x] Proof of liability insurance (or documentation that you are unable to obtain liability insurance) and a copy of the notice to parents about whether you have liability insurance.
- [x] Certificate of Good Standing or Formation (if applicable)
- [x] Policies, procedures, and documentation, as required by either Child-Placing Agency Documentation Required at Application or General Residential Operations Documentation Required at Application Checklist (if applicable)
- [x] Verification of Fee Payment (if applicable)
- [x] Request for Background Check(s)
- [ ] Form 2982, Personal History Statement (as needed)
- [x] Form 2760, Controlling Person – Child Care Licensing

Driving directions to the operation: Please provide clear and concise directions for driving to your operation from the nearest Licensing office.

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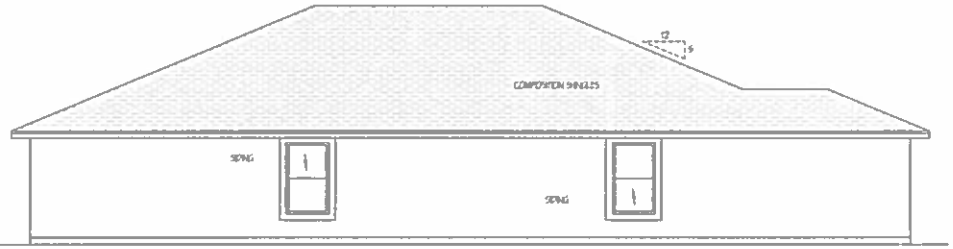
Privacy Statement

HHSC values your privacy. For more information, read the privacy policy online at: https://hhs.texas.gov/policies-practices-privacy#security.

DORMS 1-10

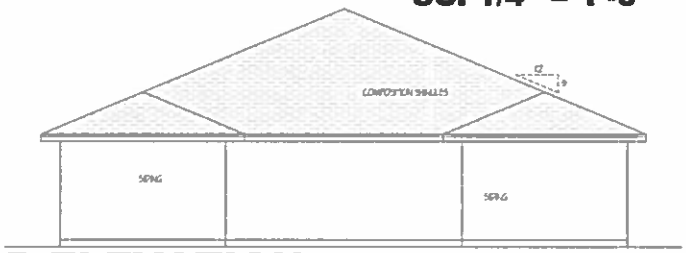
ONT ELEVATION

SC. 1/4" = 1'-0"



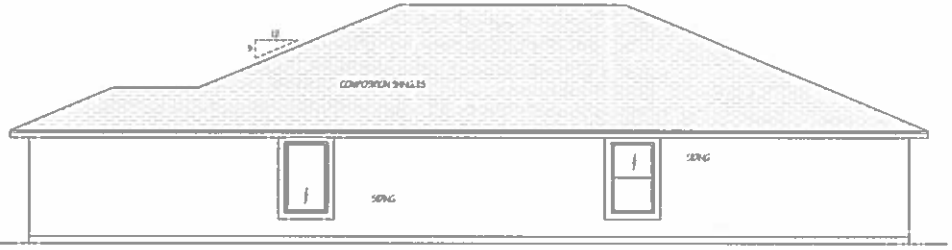
RIGHT ELEVATION

SC. 1/4" = 1'-0"



REAR ELEVATION

SC. 1/4" = 1'-0"



LEFT ELEVATION

SC. 1/4" = 1'-0"

STANFORD HOUSE
33918 STANFORD
LOS FRESNOS, TX

MANZI INVESTMENTS

PROJECT: STANFORD HOUSE
SCALE:1/64"=1'-0"

TEXAS
Health and Human Services

Form 2971
January 2019-E

Child Care Licensing Request for Background Check

Use this form to request background checks required by Texas Administrative Code (TAC) §745.605. You can also submit background check requests through HHSC's Child Care Provider website.

See the chart below for instructions based on operation type for submitting background check requests.

If,	Then,
Your operation is a licensed child care center, school-age program, before- or after-school program, licensed child care home, registered home or residential care provider,	your operation must submit background check requests via HHSC's, Child Care Provider page.
Your operation is a listed family home, employer-based child care operation or shelter operation,	your operation may submit background check requests via HHSC's Child Care Provider page, email the form to CBCUbackgroundchecks@dfps.state.tx.us, fax the background check form to 512-339-5871, or mail the background check form to: HHSC, Centralized Background Check Unit, P.O. Box 149030, Mail Code 121-7, Austin, TX 78714-9030.

Directions: Complete the following information for each person required to have a background check. Download additional forms from the HHS forms website https://hhs.texas.gov/laws-regulations/forms.

Operation Information

Operation Name	Operation No.	Operation Area Code and Telephone No.
CHS Stanford House Shelter		[redacted]
Operation Address (Street, City, State, ZIP Code) [redacted]		
Operation Mailing Address (Street, City, State, ZIP Code) [redacted]		County [redacted]

Verification Signatures

I verified (by reviewing the person's Social Security card or driver license) that the information on this form contains no willful misrepresentation, and that the information given is true and complete to the best of my knowledge. I understand that HHSC may contact others and, at any time, seek proof of any information contained here. I understand that any willful misrepresentation or failure to provide identifying information within the stated time limit is a cause for denial of the application or revocation of my license, registration, or listing.

Keith Rigdon	[signature]	7/11/2019
Printed Name of Director, Owner or Operator	Signature of Director, Owner or Operator	Date Signed

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Individual's Identifying Information

☐ Initial ☐ Renewal ☐ Fingerprint Check Required ☐ FBI Results in DPS Clearinghouse

First Name	Middle Name	Last Name
Claudia	Janet	Rivera

List any other names the individual uses or has used in the past, including married and maiden names, below. If you do not provide every name that the individual has used, you may receive inaccurate results.

Other First Names	Other Middle Names	Other Last Names
Claudia	Janet	Gonzalez

Address (Street, City, State, ZIP Code) [redacted]

County	Area Code and Telephone No.	Date of Birth	Gender:
Cameron	[redacted]	[redacted]	○Male ◉Female

List any other city in Texas where the person has been a resident and any addresses, including county, where the person has lived outside of Texas in the previous five years.

Ethnicity (must accompany race):	Race
◉Hispanic ○Non-Hispanic	○Asian ○Black ◉White ○Native Hawaiian/Pacific Islander ○American Indian/Alaskan Native

Social Security No. [redacted]

Photo ID Type:

☑ Driver License: No. [redacted] State [redacted]

☐ State ID: _____

☐ Passport: _____

☐ Canadian SIN: _____

☐ Military ID: _____

☐ Permanent Resident Card: _____

Contact information is required to schedule a fingerprint appointment. You must select one of the following choices and provide either an email address or phone number for the individual. Preferred method of contact for scheduling fingerprint appointment:

◉ Email CRivera04@chsmedical.com ○ Area Code and Telephone No. _____

Please enter the person's email address. Do NOT enter the operation's email address. Providing an email address will allow notifications requiring action from this person to be received quickly.

Role at Operation:

○ Adoptive Parent ○ Contracted Service Provider ○ Director ○ Foster Parent ○ Foster/Adoptive Parent
○ Household Member ○ Frequent/Regular Visitor ◉ Licensed Administrator ○ Owner/Permit Holder
○ Staff/Employee ○ Unverified Respite Provider ○ Volunteer

Job Duties/Title:
Program Director- Licensed Child Care Administrator:
Responsible and accountable for the daily operations and activities, which include administration, financial reports development, data collection and ensuring/monitoring contract performance in accordance with ORR policies and procedures, Cooperative Agreement, licensing minimum standards, and all other applicable state and federal law, rules, and guidelines.

For foster/adoptive homes only: Relationship between child/children to be placed and the foster/adoptive parent(s) or prospective foster/adoptive parent(s):

○ Relative ○ Fictive Kin ○ Unrelated

Will this person be supervised by a caregiver who is counted in the child-caregiver ratio?..... ○Yes ◉No

(The supervising caregiver should be an employee of your operation or a caregiver in a foster and/or adoptive home who is otherwise able to have unsupervised access to children in your care, and who is not restricted from supervising others.)

What age(s) of children will this person be caring for?

◉ 0 – 17 months ○ 18 months – 2 years ○ 3 years – 4 years ○ 5 years – 13 years ○ 14 years – 17 years
○ Over 17 years ○ N/A

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TEXAS
Health and Human Services

Form 2971
January 2019-E

Child Care Licensing Request for Background Check

Use this form to request background checks required by Texas Administrative Code (TAC) §745.605. You can also submit background check requests through HHSC's Child Care Provider website.

See the chart below for instructions based on operation type for submitting background check requests.

If,	Then,
Your operation is a licensed child care center, school-age program, before- or after-school program, licensed child care home, registered home or residential care provider,	your operation must submit background check requests via HHSC's, Child Care Provider page.
Your operation is a listed family home, employer-based child care operation or shelter operation,	your operation may submit background check requests via HHSC's Child Care Provider page, email the form to CBCUbackgroundchecks@dfps.state.tx.us, fax the background check form to 512-339-5871, or mail the background check form to: HHSC, Centralized Background Check Unit, P.O. Box 149030, Mail Code 121-7, Austin, TX 78714-9030.

Directions: Complete the following information for each person required to have a background check. Download additional forms from the HHS forms website https://hhs.texas.gov/laws-regulations/forms.

Operation Information

Operation Name	Operation No.	Operation Area Code and Telephone No.
CHS Stanford House Shelter		[redacted]
Operation Address (Street, City, State, ZIP Code) [redacted]		
Operation Mailing Address (Street, City, State, ZIP Code) [redacted]		County [redacted]

Verification Signatures

I verified (by reviewing the person's Social Security card or driver license) that the information on this form contains no willful misrepresentation, and that the information given is true and complete to the best of my knowledge. I understand that HHSC may contact others and, at any time, seek proof of any information contained here. I understand that any willful misrepresentation or failure to provide identifying information within the stated time limit is a cause for denial of the application or revocation of my license, registration, or listing.

Keith Rigdon		7/11/2019
Printed Name of Director, Owner or Operator	Signature of Director, Owner or Operator	Date Signed

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Individual's Identifying Information

☐ Initial ☐ Renewal ☐ Fingerprint Check Required ☐ FBI Results in DPS Clearinghouse

First Name	Middle Name	Last Name
Francisco	Fabian	Delgado

List any other names the individual uses or has used in the past, including married and maiden names, below. If you do not provide every name that the individual has used, you may receive inaccurate results.

Other First Names	Other Middle Names	Other Last Names

Address (Street, City, State, ZIP Code) [redacted]

County	Area Code and Telephone No.	Date of Birth	Gender:
Cameron	[redacted]	[redacted]	◉Male ○Female

List any other city in Texas where the person has been a resident and any addresses, including county, where the person has lived outside of Texas in the previous five years.

Ethnicity (must accompany race):
◉Hispanic
○Non-Hispanic

Race
○Asian ○Black ◉White ○Native Hawaiian/Pacific Islander
○American Indian/Alaskan Native

Social Security No. [redacted]

Photo ID Type:
☑ Driver License: No [redacted] State [redacted]
☐ State ID: _____
☐ Passport: _____
☐ Canadian SIN: _____
☐ Military ID: _____
☐ Permanent Resident Card: _____

Contact information is required to schedule a fingerprint appointment. You must select one of the following choices and provide either an email address or phone number for the individual. Preferred method of contact for scheduling fingerprint appointment:

◉ Email fdelgado@chsmedical.com ○ Area Code and Telephone No. _____

Please enter the person's email address. Do NOT enter the operation's email address. Providing an email address will allow notifications requiring action from this person to be received quickly.

Role at Operation:
○ Adoptive Parent ○ Contracted Service Provider ○ Director ○ Foster Parent ○ Foster/Adoptive Parent
○ Household Member ○ Frequent/Regular Visitor ○ Licensed Administrator ○ Owner/Permit Holder
◉ Staff/Employee ○ Unverified Respite Provider ○ Volunteer

Job Duties/Title:
Assistant Program Director: •
Assists the Program Director in the management of the overall operation of the program in accordance with ORR policies and procedures, Cooperative Agreement, licensing minimum standards, and all other applicable state and federal law, rules, and guidelines.

For foster/adoptive homes only: Relationship between child/children to be placed and the foster/adoptive parent(s) or prospective foster/adoptive parent(s):
○ Relative ○ Fictive Kin ○ Unrelated

Will this person be supervised by a caregiver who is counted in the child-caregiver ratio?..... ○Yes ◉No

(The supervising caregiver should be an employee of your operation or a caregiver in a foster and/or adoptive home who is otherwise able to have unsupervised access to children in your care, and who is not restricted from supervising others.)

What age(s) of children will this person be caring for?
◉ 0 – 17 months ○ 18 months – 2 years ○ 3 years – 4 years ○ 5 years – 13 years ○ 14 years – 17 years
○ Over 17 years ○ N/A

TEXAS
Health and Human Services

Form 2760
May 2018-E

Controlling Person – Child Care Licensing

Directions: Complete the required information for each controlling person with your operation. This includes all people in the operation, as stated under Title 40 Texas Administrative Code §745.901 for the definition of controlling person. **Note**: The rules may transfer to Title 26 at a later date.

Operation Information

Operation Name:	Operation No.:	Area Code and Telephone No.:
CHS Stanford House Shelter		[redacted]
Address of Operation (Street, City, State and ZIP Code): [redacted]		County: [redacted]

Acknowledgment and Signature

The information on this form contains no willful misrepresentation. The information given is true and complete to the best of my knowledge. I understand that any willful misrepresentation or failure to provide identifying information within the required time frames is a cause for remedial action regarding my application or permit.

Signature of Applicant, Designee, or Head of the Governing Body — Date: 7/11/2019

Applicant Information

First Name:	Middle Name:	Last Name:	Suffix:
Claudia	Janet	Rivera	
Other names used (married, maiden, etc.)			
First Name:	Middle Name:	Last Name:	Suffix:
Claudia	Janet	Gonzalez	

Date of Birth:	Driver License No.:	Driver License State:	Social Security No.:
[redacted]	[redacted]	Texas	[redacted]

Individual's Address (Street, City, State and ZIP Code):	Area Code and Telephone No.:
2794 Picasso Ln, Brownsville, Texas 78520	[redacted]

Title, Position or Relationship:

- [x] Licensed Administrator
- [x] Director
- [ ] Board Member
- [ ] Governing Body Member
- [ ] Chief Executive Officer
- [ ] Owner
- [ ] Primary Caregiver in Child Care Home
- [ ] Spouse of Primary Caregiver
- [ ] Adult Living in Child Care Home
- [ ] Other: _____

Effective Date of Title, Position or Relationship:

If person is associated with a child placing agency, indicate if the person is associated with the main or branch office:

◯ Main ◯ Branch If branch, what number:

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HHSC Use Only

Name of Licensing Staff Completing Adverse Action Record Sharing (AARS) System Check:	Mail Code:

Date Form Received:	Date AARS Check Completed:	AARS Status: ◯ Cleared ◯ Match

Applicant Information

First Name:	Middle Name:	Last Name:	Suffix:
Francisco	Fabian	Delgado	

Other names used (married, maiden, etc.)

First Name:	Middle Name:	Last Name:	Suffix:

Date of Birth:	Driver License No.:	Driver License State:	Social Security No.:
[redacted]			

Individual's Address (Street, City, State and ZIP Code): [redacted]

Area Code and Telephone No.: [redacted]

Title, Position or Relationship:

- ☐ Licensed Administrator
- ☐ Governing Body Member
- ☐ Primary Caregiver in Child Care Home
- ☐ Director
- ☐ Chief Executive Officer
- ☐ Spouse of Primary Caregiver
- ☐ Board Member
- ☐ Owner
- ☐ Adult Living in Child Care Home
- ☑ Other: Assistant Program Director

Effective Date of Title, Position or Relationship:

If person is associated with a child placing agency, indicate if the person is associated with the main or branch office:

○ Main ○ Branch If branch, what number:

Applicant Information

First Name:	Middle Name:	Last Name:	Suffix:
Melissa	Denice	Aguilar	

Other names used (married, maiden, etc.)

First Name:	Middle Name:	Last Name:	Suffix:
Melissa	Denice	DeLeon	

Date of Birth:	Driver License No.:	Driver License State:	Social Security No.:
[redacted]			

Individual's Address (Street, City, State and ZIP Code): [redacted]

Area Code and Telephone No.: [redacted]

Title, Position or Relationship:

- ☐ Licensed Administrator
- ☑ Governing Body Member
- ☐ Primary Caregiver in Child Care Home
- ☐ Director
- ☐ Chief Executive Officer
- ☐ Spouse of Primary Caregiver
- ☐ Board Member
- ☐ Owner
- ☐ Adult Living in Child Care Home
- ☑ Other: RGV Program Coordinator

Effective Date of Title, Position or Relationship:
06/10/2018

If person is associated with a child placing agency, indicate if the person is associated with the main or branch office:

○ Main ○ Branch If branch, what number:

Applicant Information

First Name:	Middle Name:	Last Name:	Suffix:
Keith	Allen	Rigdon	
Other names used (married, maiden, etc.)			
First Name:	Middle Name:	Last Name:	Suffix:

Date of Birth:	Driver License No.:	Driver License State:	Social Security No.:
[redacted]			

Individual's Address (Street, City, State and ZIP Code):	Area Code and Telephone No.:
[redacted]	[redacted]

Title, Position or Relationship:

- ☐ Licensed Administrator
- ☑ Governing Body Member
- ☐ Primary Caregiver in Child Care Home
- ☐ Director
- ☐ Chief Executive Officer
- ☐ Spouse of Primary Caregiver
- ☐ Board Member
- ☐ Owner
- ☐ Adult Living in Child Care Home
- ☑ Other: Vice-President,Humanitarian & Immigration Services

Effective Date of Title, Position or Relationship:
06/10/2018

If person is associated with a child placing agency, indicate if the person is associated with the main or branch office:

◯ Main ◯ Branch If branch, what number:

TEXAS
Health and Human Services

Form 2819
June 2018-E

Residential Child Care Licensing Governing Body/Administrator or Executive Director Designation

Use this form to designate an official representative (designee) to speak and act on your organization's behalf. Also use this form to designate an administrator or executive director.

Directions: To complete this form, fill out Section A to name a designee and/or Section B to designate an administrator or executive director. The Certification and Signature section must be completed to verify information in Section A and/or Section B. For more information, contact your Licensing representative.

Section A – Official Representative (Designee)

Operation Name: CHS Stanford House Shelter	Operation Number:	Telephone Number: (956) 233-0812
Governing Body or Organization Name: Comprehensive Health Services, LLC		Telephone Number: (321) 868-8500
Name of Chief Executive Officer (CEO) or Head of Governing Body: Keith Rigdon		Telephone Number: (321) 868-8500
Send routine correspondence to the CEO or Head of Governing Body?		◉ Yes ○ No
Name of Designee of Governing Body: Melissa Aguilar		Telephone Number: (956) 233-0812

Operation Street Address: [redacted]	City: Los Fresnos	County: Cameron	ZIP Code: [redacted]
Governing Body or Organization's Street Address: 8600 Astronaut Blvd	City: Cape Canaveral	County: Brevard	ZIP Code: 32920-4306
CEO or Head of Governing Body's Street Address: 8600 Astronaut Blvd	City: Cape Canaveral	County: Brevard	ZIP Code: 32920-4306
Designee Street Address: [redacted]	City: Los Fresnos	County: Cameron	ZIP Code: [redacted]

Section B — Administrator or Executive Director

Name of Administrator or Executive Director: Melissa Aguilar, Administrator

Certification and Signature

By completing Section A of this form, I hereby designate the person noted as the official representative (designee) to speak for and act on our organization's behalf. I understand that all correspondence and copies of compliance documents will be sent to the designee. I understand that as the permit holder, the governing body is ultimately responsible for maintaining compliance with the child care licensing law and minimum standards. I understand that all waivers and variances must be requested and signed by me or by the designee. I understand that any time there is a change in the designee of an operation, the governing body is responsible for notifying Licensing. I understand that Licensing will notify the governing body and all controlling persons of compliance documents and remedial action against the operation. By completing Section B of this form, I hereby designate the person noted as the administrator or executive director of my operation.

Signature Of Chief Executive Officer, Head of the Governing Body, Each Partner, or Designee	Date Signed
[signature]	7/11/2019

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TX2018 05-158-A

Ver. 9.0 (Rev.9-18/9)

Texas Franchise Tax Report - Page 1

Tcode 13250 ANNUAL

Taxpayer number	Report year	Due date
15210446280	2018	05/15/2018

Taxpayer name: COMPREHENSIVE HEALTH SERVICES, INC.

Secretary of State file number or Comptroller file number: 15210446280

Mailing address: 8810 ASTRONAUT BLVD.

City	State	Country	ZIP code plus 4	Check box if the address has changed
CAPE CANAVERAL	FL	USA	32920	☐

Check box if this is a combined report ☐

Check box if Total Revenue is adjusted for Tiered Partnership Election, see instructions ☐

Is this entity a corporation, limited liability company, professional association, limited partnership or financial institution? ☒ Yes ☐ No

** If not twelve months, see instructions for annualized revenue

Accounting year begin date** (m m d d y y)	Accounting year end date (m m d d y y)	SIC code	NAICS code
0 1 0 1 1 7	1 2 3 1 1 7		

REVENUE *(Whole dollars only)*

1. Gross receipts or sales		1.
2. Dividends		2.
3. Interest		3.
4. Rents *(can be negative amount)*		4.
5. Royalties		5.
6. Gains/losses *(can be negative amount)*		6.
7. Other income *(can be negative amount)*		7.
8. Total gross revenue *(Add items 1 thru 7)*	8.	
9. Exclusions from gross revenue *(see instructions)*	9.	
10. TOTAL REVENUE *(item 8 minus item 9 if less than zero, enter 0)*	10.	

COST OF GOODS SOLD *(Whole dollars only)*

11. Cost of goods sold	11.	
12. Indirect or administrative overhead costs *(Limited to 4%)*	12.	
13. Other *(see instructions)*	13.	
14. TOTAL COST OF GOODS SOLD *(Add items 11 thru 13)*	14.	

COMPENSATION *(Whole dollars only)*

15. Wages and cash compensation	15.	
16. Employee benefits	16.	
17. Other *(see instructions)*	17.	
18. TOTAL COMPENSATION *(Add items 15 thru 17)*	18.	

[redacted]

Texas Comptroller Official Use Only

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VE/DE	☐
PM Date	

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TX2018 05-158-B

Ver. 9.0 (Rev 9-18/9)

Texas Franchise Tax Report - Page 2

[redacted]

■ Tcode 13251 ANNUAL

■ Taxpayer number	■ Report year	Due date	Taxpayer name
15210446280	2018	05/15/2018	COMPREHENSIVE HEALTH SERVICES, INC.

MARGIN *(Whole dollars only)*

19. **70% revenue** *(item 10 X .70)* 19. ■

20. **Revenue less COGS** *(item 10 - item 14)* 20. ■

21. **Revenue less compensation** *(item 10 - item 18)* 21. ■

22. **Revenue less $1 million** *(item 10 - $1,000,000)* 22. ■

23. **MARGIN** *(see instructions)* 23. ■

APPORTIONMENT FACTOR

24. **Gross receipts in Texas** *(Whole dollars only)* 24. ■

25. **Gross receipts everywhere** *(Whole dollars only)* 25. ■

26. **APPORTIONMENT FACTOR** *(Divide item 24 by item 25, round to 4 decimal places)* 26.

TAXABLE MARGIN *(Whole dollars only)*

27. **Apportioned margin** *(Multiply item 23 by item 26)* 27. ■

28. **Allowable deductions** *(see instructions)* 28. ■

29. **TAXABLE MARGIN** *(item 27 minus item 28)* 29. ■

TAX DUE

30. **Tax rate** *(see instructions for determining the appropriate tax rate)* X X X 30. ■

31. **Tax due** (Multiply item 29 by the tax rate in item 30) (Dollars and cents) 31. ■

TAX ADJUSTMENTS *(Dollars and cents) (Do not include prior payments)*

32. **Tax credits** *(item 23 from Form 05-160)* 32. ■

33. **Tax due before discount** *(item 31 minus item 32)* 33. ■

34. **Discount** (see instructions, applicable to report years 2008 and 2009) 34. ■

TOTAL TAX DUE *(Dollars and cents)*

35. **TOTAL TAX DUE** *(item 33 minus item 34)* 35. ■

Do not include payment if item 35 is less than $1,000 or if annualized total revenue is less than the no tax due threshold (see instructions). If the entity makes a tiered partnership election, ANY amount in item 35 is due. Complete Form 05-170 if making a payment.

Print or type name	Area code and phone number
JAMES VAN DUSEN	(321) 783-2720

I declare that the information in this document and any attachments is true and correct to the best of my knowledge and belief.

sign here ▶ [signature] Date 3/14/2018

Mail original to:
Texas Comptroller of Public Accounts
P.O. Box 149348
Austin, TX 78714-9348

Instructions for each report year are online at www.comptroller.texas.gov/taxes/franchise/forms/. If you have any questions, call 1-800-252-1381.

Texas Comptroller Official Use Only

VE/DE	
PM Date	

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TX 05-102 (Section A Continuation)

COMPREHENSIVE HEALTH SERVICES, INC. 15210446280

Name	Title	Director	Term expiration	
JAMES D. VAN DUSEN	CFO/TREASURER	☐ YES		
[redacted]	City NAPLES		State FL	ZIP Code 34110

Name	Title	Director	Term expiration	
CASPER JONES	SR VICE PRES.	☐ YES		
[redacted]	City COCOA BEACH		State FL	ZIP Code 32922

Name	Title	Director	Term expiration	
DANIEL JONES	SR VICE PRES.	☐ YES		
[redacted]	City MELBOURNE		State FL	ZIP Code 32940

Name	Title	Director	Term expiration	
DOUGLAS MAGEE	SR VICE PRES.	☐ YES		
[redacted]	City AIDIE		State VA	ZIP Code 20105

Name	Title	Director	Term expiration	
EDWIN P. COOPER III	DIRECTOR	☒ YES		
[redacted]	City WINTER PARK		State FL	ZIP Code 32789

Name	Title	Director	Term expiration	
JOSEPH J. MAIGNOGNA	CHIEF MED OFICR	☐ YES		
[redacted]	City MELBOURNE		State FL	ZIP Code 32940

Name	Title	Director	Term expiration	
MORRILL M. HALL, JR	DIRECTOR	☒ YES		
[redacted]	City COCOA BEACH		State FL	ZIP Code 32931

Name	Title	Director	Term expiration	
TODD S. HALL	SECRETARY	☒ YES		
[redacted]	City RESTON		State VA	ZIP Code 20191

Name	Title	Director	Term expiration	
		☐ YES		
Mailing address	City		State	ZIP Code

Name	Title	Director	Term expiration	
		☐ YES		
Mailing address	City		State	ZIP Code

Name	Title	Director	Term expiration	
		☐ YES		
Mailing address	City		State	ZIP Code

1334345 780701

TX2018 05-102

Ver. 9.0 (Rev.9-15/33)

Texas Franchise Tax Public Information Report

To be filed by Corporations, Limited Liability Companies (LLC), Limited Partnerships (LP), Professional Associations (PA) and Financial Institutions

■ Tcode 13196

■ Taxpayer number 15210446280

■ Report year 2018

You have certain rights under Chapter 552 and 559, Government Code, to review, request and correct information we have on file about you. Contact us at 1-800-252-1361.

Taxpayer name COMPREHENSIVE HEALTH SERVICES, INC.		■ ☐ Check box if the mailing address has changed.	
Mailing address 8810 ASTRONAUT BLVD.			Secretary of State (SOS) file number or Comptroller file number 1521044628
City CAPE CANAVERAL	State FL	ZIP code plus 4 32920	

☐ Check box if there are currently no changes from previous year; if no information is displayed, complete the applicable information in Sections A, B and C.

Principal office	8810 ASTRONAUT BLVD., CAPE CANAVERAL, FL 32920
Principal place of business	8810 ASTRONAUT BLVD., CAPE CANAVERAL, FL 32920

You must report officer, director, member, general partner and manager information as of the date you complete this report.

Please sign below!

This report must be signed to satisfy franchise tax requirements.

1521044628018

SECTION A Name, title and mailing address of each officer, director, member, general partner or manager.

Name	Title	Director	Term expiration (m m d d y y)	
GARY G. PALMER	PRESIDENT	[X] YES	010120	
Mailing address [redacted]	City COCOA VILLAGE		State FL	ZIP Code 32922
Name	Title	Director	Term expiration (m m d d y y)	
JUDY C. HALL	DIRECTOR	[X] YES		
Mailing address [redacted]	City COCOA BEACH		State FL	ZIP Code 32931
Name	Title	Director	Term expiration (m m d d y y)	
JAMES MONCRIEF	DIRECTOR	[X] YES		
Mailing address [redacted]	City ATHENS		State GA	ZIP Code 30606

SECTION B Enter information for each corporation, LLC, LP, PA or financial institution, if any, in which this entity owns an interest of 10 percent or more.

Name of owned (subsidiary) corporation, LLC, LP, PA or financial institution	State of formation	Texas SOS file number, if any	Percentage of ownership
Name of owned (subsidiary) corporation, LLC, LP, PA or financial institution	State of formation	Texas SOS file number, if any	Percentage of ownership

SECTION C Enter information for each corporation, LLC, LP, PA or financial institution, if any, that owns an interest of 10 percent or more in this entity.

Name of owned (parent) corporation, LLC, LP, PA or financial institution	State of formation	Texas SOS file number, if any	Percentage of ownership
COMPREHENSIVE HEALTH HOLDINGS INC	DE	453633110	100.00

Registered agent and registered office currently on file (see instructions if you need to make changes)

You must make a filing with the Secretary of State to change registered agent, registered office or general partner information.

Agent: THE C T CORPORATION SYSTEM

Office: 350 NORTH ST PAUL ST, STE 2900 City DALLAS State TX ZIP Code 75201

The information on this form is required by Section 171.203 of the Tax Code for each corporation, LLC, LP, PA or financial institution that files a Texas Franchise Tax Report. Use additional sheets for Sections A, B and C, if necessary. The information will be available for public inspection.

I declare that the information in this document and any attachments is true and correct to the best of my knowledge and belief, as of the date below, and that a copy of this report has been mailed to each person named in this report who is an officer, director, member, general partner or manager and who is not currently employed by this or a related corporation, LLC, LP, PA or financial institution.

sign here ▶	Title	Date	Area code and phone number
	TREASURER		(321) 783-2720

Texas Comptroller Official Use Only

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TEXAS
Health and Human Services

Form 2962
May 2018-E

Verification of Liability Insurance

Use this form to indicate whether your operation has liability insurance as required by Human Resources Code §42.049. Applicants to operate a registered child care home, listed family home, small employer-based child care operation, temporary-shelter day care program, or state-operated facility do not require liability insurance.

Directions: The permit holder completes this form in its entirety and sends it to Child Care Licensing as part of an application for a license

General Information

Operation Name:	Operation Number:
CHS Stanford House Shelter	

Operation Address:
[redacted]

Does your operation have liability insurance in the amount of $300,000 for each occurrence of negligence covering injury to a child?

- (●) Yes (if yes, attach a copy of the certificate of insurance) If yes, renewal date: 11-01-2019
- ( ) **No. This operation does not have liability of insurance as required by Section 42.049 of the Human Resource Code for the following reason:**
  - ( ) Financial reasons; provide explanation:
  - ( ) Coverage not available from an underwriter; provide explanation:
  - ( ) The limitations of the current policy have been exhausted. Date the policy will be available:

Notification of Lack of Insurance

Parents have been, or will be, notified by (check all that apply):

- [ ] Letter or pamphlet to parents (attach a copy)
- [ ] Notice posted in a prominent place (attach a copy)
- [ ] A statement is on the enrollment form (attach a copy)
- [ ] Posted on the operation's website
- [ ] Other (specify):

Certification and Signature

Signature of Permit Holder, Designee or Director	Date Signed
[signature]	7/11/2019

RECEIVED JUL 22 2019

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 05/28/2019

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Marsh USA Inc. Three James Center 1051 East Cary Street, Suite 900 Richmond, VA 23219 Attn. HealthcareAccountsCSS@marsh.com/Fax: 212-948-1307 CN102581481-All-Ba/PL-18-19	**CONTACT NAME:** **PHONE (A/C, No, Ext):** **FAX (A/C, No):** **E-MAIL ADDRESS:**
INSURED Comprehensive Health Services, Inc. 10701 Parkridge Blvd. Reston, VA 20191	**INSURER(S) AFFORDING COVERAGE** — **NAIC #** **INSURER A :** Beazley Insurance Company **INSURER B :** Starr Indemnity & Liability Company — 38318 **INSURER C :** Commerce and Industry Insurance Company **INSURER D :** **INSURER E :** **INSURER F :**

COVERAGES **CERTIFICATE NUMBER:** ATL-004894741-07 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC OTHER:			[redacted]	11/01/2018	11/01/2019	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 10,000,000 $ 300,000 $ $ 10,000,000 $ 10,000,000 $ 10,000,000
B	AUTOMOBILE LIABILITY X ANY AUTO OWNED AUTOS ONLY / SCHEDULED AUTOS X HIRED AUTOS ONLY / X NON-OWNED AUTOS ONLY				11/01/2018	11/01/2019	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 2,000,000 $ $ $
C	X UMBRELLA LIAB / X OCCUR EXCESS LIAB / CLAIMS-MADE DED / RETENTION $ 0				11/01/2018	11/01/2019	EACH OCCURRENCE AGGREGATE	$ 15,000,000 $ 15,000,000
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		See 2nd Page for Addtl WC Policies	11/01/2018	11/01/2019	X PER STATUTE / OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 1,000,000 $ 1,000,000 $ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

RE: Los Fresnos Shelter 32120 FM 1847 Los Fresnos, TX 78566

CERTIFICATE HOLDER

Comprehensive Health Services, Inc.
10701 Parkridge Blvd. #200
Reston, VA 20191-4359

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE of Marsh USA Inc.

Timothy J. Brandt

RECEIVED JUL 2 2 2019

AGENCY CUSTOMER ID: CN102581481
LOC #: Nashville

ADDITIONAL REMARKS SCHEDULE

AGENCY	NAMED INSURED
Marsh USA Inc.	Comprehensive Health Services, Inc. 10701 Parkridge Blvd Reston, VA 20191
POLICY NUMBER	
CARRIER / NAIC CODE	EFFECTIVE DATE:

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,
FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

Additional Workers Compensation Policies

Starr Indemnity & Liability Company
Policy [redacted] (VA, AL, AR, AK, CA, CO, GA, MD, MN, NV, OR, SC, TN)
Policy Dates: 11/01/2018 - 11/01/2019
Limits: Per Statute
$1,000,000 - Employers Liability Each Accident
$1,000,000 - Employers Liability Disease - Policy Limit
$1,000,000 - Employers Liability Disease - Each Employee

Starr Indemnity & Liability Company
Polic[redacted]AK, FL)
Policy Dates: 11/01/2018 - 11/01/2019
Limits: Per Statute
$1,000,000 - Employers Liability Each Accident
$1,000,000 - Employers Liability Disease - Policy Limit
$1,000,000 - Employers Liability Disease - Each Employee

EVIDENCE OF PROPERTY INSURANCE

DATE (MM/DD/YYYY): 05/28/2019

THIS EVIDENCE OF PROPERTY INSURANCE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE ADDITIONAL INTEREST NAMED BELOW. THIS EVIDENCE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS EVIDENCE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE ADDITIONAL INTEREST.

AGENCY
Marsh USA Inc.
Three James Center
1051 East Cary Street, Suite 900
Richmond, VA 23219
Attn: Healthcare.AccountsCSS@marsh.com/Fax: 212-948-1307
CN102581481—18-19

PHONE (A/C, No, Ext):

FAX (A/C, No):

E-MAIL ADDRESS:

CODE:

SUB CODE:

AGENCY CUSTOMER ID #:

COMPANY
Markel American Insurance Company

INSURED
Comprehensive Health Services, Inc.
10701 Parkridge Blvd.
Reston, VA 20191

LOAN NUMBER

POLICY NUMBER [redacted]

EFFECTIVE DATE	EXPIRATION DATE	CONTINUED UNTIL TERMINATED IF CHECKED
11/01/2018	11/01/2019	☐

THIS REPLACES PRIOR EVIDENCE DATED:

PROPERTY INFORMATION

LOCATION/DESCRIPTION
R[redacted]

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS EVIDENCE OF PROPERTY INSURANCE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

COVERAGE INFORMATION

PERILS INSURED: ☐ BASIC ☐ BROAD ☒ SPECIAL ☐

COVERAGE / PERILS / FORMS	AMOUNT OF INSURANCE	DEDUCTIBLE
Risk of Direct Physical Loss or Damage to Personal Property on a Replacement Cost Basis, subject to Policy Terms and Exclusions Blanket All Locations	15,000,000	5,000
Earthquake	1,000,000	25,000
Flood	1,000,000	25,000
Other deductibles may apply as per policy terms and conditions.		

REMARKS (Including Special Conditions)

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

ADDITIONAL INTEREST

ATL-004950880-01

NAME AND ADDRESS
Comprehensive Health Services, Inc.
10701 Parkridge Blvd. #200
Reston, VA 20191-4359

☐ ADDITIONAL INSURED ☐ LENDER'S LOSS PAYABLE ☐ LOSS PAYEE
☐ MORTGAGEE

RECEIVED JUN 22 2019

LOAN #

AUTHORIZED REPRESENTATIVE of Marsh USA Inc.
Timothy J. Brandt

ACORD 27 (2016/03)

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 05/28/2019

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Marsh USA Inc. Three James Center 1051 East Cary Street, Suite 900 Richmond, VA 23219 Attn: Healthcare.AccountsCSS@marsh.com/Fax: 212-948-1307 CN102581481-All-Ba/PL-18-19	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:
INSURED Comprehensive Health Services, Inc. 10701 Parkridge Blvd. Reston, VA 20191	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : Beazley Insurance Company INSURER B : Starr Indemnity & Liability Company — 38318 INSURER C : Commerce and Industry Insurance Company INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** ATL-004890805-05 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE [ ] OCCUR [X] GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY [ ] PRO-JECT [ ] LOC OTHER:			[redacted]	11/01/2018	11/01/2019	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 10,000,000 $ 300,000 $ $ 10,000,000 $ 10,000,000 $ 10,000,000
B	AUTOMOBILE LIABILITY X ANY AUTO OWNED AUTOS ONLY / SCHEDULED AUTOS X HIRED AUTOS ONLY / X NON-OWNED AUTOS ONLY				11/01/2018	11/01/2019	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 2,000,000 $ $ $
C	X UMBRELLA LIAB / X OCCUR EXCESS LIAB / CLAIMS-MADE DED / RETENTION $ 0				11/01/2018	11/01/2019	EACH OCCURRENCE AGGREGATE	$ 15,000,000 $ 15,000,000
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: N — N/A If yes, describe under DESCRIPTION OF OPERATIONS below			(AZ, TX, NC, NY) See 2nd Page for Addl WC Policies	11/01/2018	11/01/2019	X PER STATUTE / OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 1,000,000 $ 1,000,000 $ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
RE: 299 E Heywood, San Benito, TX 78586

RECEIVED JUL 22 2019

CERTIFICATE HOLDER

Comprehensive Health Services, Inc.
10701 Parkridge Blvd. #200
Reston, VA 20191-4359

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

RECEIVED JUL 22 2019

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.

Timothy J. Brandt — Timothy J. Brandt

AGENCY CUSTOMER ID: CN102581481
LOC #: Nashville

ACORD

ADDITIONAL REMARKS SCHEDULE

AGENCY	NAMED INSURED
Marsh USA Inc.	Comprehensive Health Services, Inc. 10701 Parkridge Blvd. Reston, VA 20191
POLICY NUMBER	
CARRIER / NAIC CODE	EFFECTIVE DATE:

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,
FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

Additional Workers Compensation Policies

Starr Indemnity & Liability Company
Policy [redacted] (VA, AL, AR, AK, CA, CO, GA, MD, MN, NV, OR, SC, TN)
Policy Dates: 11/01/2018 - 11/01/2019
Limits: Per Statute
$1,000,000 - Employers Liability Each Accident
$1,000,000 - Employers Liability Disease - Policy Limit
$1,000,000 - Employers Liability Disease - Each Employee

Starr Indemnity & Liability Company
Policy [redacted] AK, FL)
Policy Dates: 11/01/2018 - 11/01/2019
Limits: Per Statute
$1,000,000 - Employers Liability Each Accident
$1,000,000 - Employers Liability Disease - Policy Limit
$1,000,000 - Employers Liability Disease - Each Employee

EVIDENCE OF PROPERTY INSURANCE

DATE (MM/DD/YYYY): 05/28/2019

THIS EVIDENCE OF PROPERTY INSURANCE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE ADDITIONAL INTEREST NAMED BELOW. THIS EVIDENCE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS EVIDENCE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE ADDITIONAL INTEREST.

AGENCY
Marsh USA Inc.
Three James Center
1051 East Cary Street, Suite 900
Richmond, VA 23219
Attn: Healthcare.AccountsCSS@marsh.com/Fax: 212-948-1307
CN102581481—18-19

PHONE (A/C, No, Ext):

FAX (A/C, No):

E-MAIL ADDRESS:

CODE:

SUB CODE:

AGENCY CUSTOMER ID #:

COMPANY
Markel American Insurance Company

INSURED
Comprehensive Health Services, Inc.
10701 Parkridge Blvd.
Reston, VA 20191

LOAN NUMBER

POLICY NUMBER [redacted]

EFFECTIVE DATE	EXPIRATION DATE	CONTINUED UNTIL TERMINATED IF CHECKED
11/01/2018	11/01/2019	☐

THIS REPLACES PRIOR EVIDENCE DATED:

PROPERTY INFORMATION

LOCATION/DESCRIPTION
[redacted]

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS EVIDENCE OF PROPERTY INSURANCE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

COVERAGE INFORMATION

PERILS INSURED: ☐ BASIC ☐ BROAD ☒ SPECIAL ☐

COVERAGE / PERILS / FORMS	AMOUNT OF INSURANCE	DEDUCTIBLE
Risk of Direct Physical Loss or Damage to Personal Property on a Replacement Cost Basis, subject to Policy Terms and Exclusions Blanket All Locations	15,000,000	5,000
Earthquake	1,000,000	25,000
Flood	1,000,000	25,000
Other deductibles may apply as per policy terms and conditions.		

REMARKS (Including Special Conditions)

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

ADDITIONAL INTEREST

ATL-004950684-01

NAME AND ADDRESS
Comprehensive Health Services, Inc.
10701 Parkridge Blvd. #200
Reston, VA 20191-4359

☐ ADDITIONAL INSURED ☐ LENDER'S LOSS PAYABLE ☐ LOSS PAYEE
☐ MORTGAGEE

LOAN #

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Timothy J. Brandt

RECEIVED JUN 2 2 2019

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 05/28/2019

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Marsh USA Inc.
Three James Center
1051 East Cary Street, Suite 900
Richmond, VA 23219
Attn: Healthcare.AccountsCSS@marsh.com/Fax: 212-948-1307
CN102581481-All-Ba/PL-18-19

CONTACT NAME:
PHONE (A/C, No, Ext): **FAX (A/C, No):**
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Beazley Insurance Company	
INSURER B : Starr Indemnity & Liability Company	38318
INSURER C : Commerce and Industry Insurance Company	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Comprehensive Health Services, Inc.
10701 Parkridge Blvd.
Reston, VA 20191

COVERAGES **CERTIFICATE NUMBER:** ATL-004894736-07 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY			[redacted]	11/01/2018	11/01/2019	EACH OCCURRENCE	$ 10,000,000
	CLAIMS-MADE X OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 300,000
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$ 10,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 10,000,000
	X POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$ 10,000,000
	OTHER:							$
B	AUTOMOBILE LIABILITY				11/01/2018	11/01/2019	COMBINED SINGLE LIMIT (Ea accident)	$ 2,000,000
	X ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	X HIRED AUTOS ONLY / X NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
C	X UMBRELLA LIAB X OCCUR				11/01/2018	11/01/2019	EACH OCCURRENCE	$ 15,000,000
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$ 15,000,000
	DED RETENTION $ 0							$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N			(AZ, TX, NC, NY)	11/01/2018	11/01/2019	X PER STATUTE OTH-ER	
	ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N (Mandatory in NH)	N/A		See 2nd Page for Addtl WC Policies			E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
RE: Casa Norma Linda 30788 Highway 100 Los Fresnos, TX 78566

CERTIFICATE HOLDER
Comprehensive Health Services, Inc.
10701 Parkridge Blvd. #200
Reston, VA 20191-4359

CANCELLATION
SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Timothy J. Brandt — Timothy J. Brandt

RECEIVED JUN 22 2019

AGENCY CUSTOMER ID: CN102581481
LOC #: Nashville

ADDITIONAL REMARKS SCHEDULE

AGENCY	NAMED INSURED
Marsh USA Inc.	Comprehensive Health Services, Inc. 10701 Parkridge Blvd. Reston, VA 20191
POLICY NUMBER	
CARRIER / NAIC CODE	EFFECTIVE DATE:

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,
FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

Additional Workers Compensation Policies

Starr Indemnity & Liability Company
Policy: [redacted] VA, AL, AR, AK, CA, CO, GA, MD, MN, NV, OR, SC, TN)
Policy Dates: 11/01/2018 - 11/01/2019
Limits: Per Statute
$1,000,000 - Employers Liability Each Accident
$1,000,000 - Employers Liability Disease - Policy Limit
$1,000,000 - Employers Liability Disease - Each Employee

Starr Indemnity & Liability Company
Policy: [redacted] AK, FL)
Policy Dates: 11/01/2018 - 11/01/2019
Limits: Per Statute
$1,000,000 - Employers Liability Each Accident
$1,000,000 - Employers Liability Disease - Policy Limit
$1,000,000 - Employers Liability Disease - Each Employee

EVIDENCE OF PROPERTY INSURANCE

DATE (MM/DD/YYYY): 05/28/2019

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AGENCY
Marsh USA Inc.
Three James Center
1051 East Cary Street, Suite 900
Richmond, VA 23219
Attn: Healthcare.AccountsCSS@marsh.com/Fax: 212-948-1307
CN102581481---18-19

PHONE (A/C, No, Ext):

FAX (A/C, No):

E-MAIL ADDRESS:

CODE:

SUB CODE:

AGENCY CUSTOMER ID #:

COMPANY
Markel American Insurance Company

INSURED
Comprehensive Health Services, Inc.
10701 Parkridge Blvd.
Reston, VA 20191

LOAN NUMBER

POLICY NUMBER [redacted]

EFFECTIVE DATE	EXPIRATION DATE	CONTINUED UNTIL TERMINATED IF CHECKED
11/01/2018	11/01/2019	☐

THIS REPLACES PRIOR EVIDENCE DATED:

PROPERTY INFORMATION

LOCATION/DESCRIPTION
R [redacted]

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS EVIDENCE OF PROPERTY INSURANCE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

COVERAGE INFORMATION

PERILS INSURED: ☐ BASIC ☐ BROAD ☒ SPECIAL ☐

COVERAGE / PERILS / FORMS	AMOUNT OF INSURANCE	DEDUCTIBLE
Risk of Direct Physical Loss or Damage to Personal Property on a Replacement Cost Basis, subject to Policy Terms and Exclusions Blanket All Locations	15,000,000	5,000
Earthquake	1,000,000	25,000
Flood	1,000,000	25,000
Other deductibles may apply as per policy terms and conditions.		

REMARKS (Including Special Conditions)

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

ADDITIONAL INTEREST

ATL-004950875-01

NAME AND ADDRESS
Comprehensive Health Services, Inc.
10701 Parkridge Blvd. #200
Reston, VA 20191-4359

☐ ADDITIONAL INSURED ☐ LENDER'S LOSS PAYABLE ☐ LOSS PAYEE
☐ MORTGAGEE

LOAN #

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Timothy J. Brandt

TEXAS Health and Human Services

Residential Child Care License Fee Schedule

Form 3011
May 2018-E

State Law requires the Texas Health and Human Services Commission (HHSC) to collect fees for issuing licenses, registrations and listings and for conducting background checks. HHSC deposits the checks it receives in the state's general revenue fund.

Directions: Please send only **one check or money order** for the entire amount (including background check fees). **Do NOT send cash.**

Make check or money order payable to: Texas Health and Human Services Commission
Mail this completed form and your check or money order to:

Texas Health and Human Services Commission Accounts Receivable
P.O. Box 149055
Austin, TX 78714-9055

Keep a copy of your canceled check or money order for your records. No receipt will be sent.

This form and your payment will be returned to you if: the form is blank or incomplete, you do not send the correct fee amount, or you send cash.

Fee Definitions: 40 Texas Administrative Code §745.509 establishes the following fee schedule:

Application Fee: A **nonrefundable** fee of $35 for an initial application for a license to operate a child care operation or child-placing agency. The fee is paid when the application is submitted.

Initial License Fee: A $35 fee for a child care operation (other than a child-placing agency). A $50 fee for a child-placing agency. This fee is paid when the application is submitted.

Initial Renewal: A $35 fee for a child care operation. A $50 fee for a child-placing agency. The fee is paid when the initial license is renewed.

Full License Fee and Annual fee: A $35 fee for a child care operation plus $1 for each child the operation is licensed to serve (other than a child-placing agency); a $100 fee for a child-placing agency. This fee is paid before the full license is issued and at the anniversary date of issuance.

Background Check Fee: A $2 fee per person, paid each time a Criminal History and Central Registry background check is requested.

The law requires that if an operation fails to pay the annual license fee when due, the license will be suspended until the fee is paid. This means children must not be in care at the operation until the suspension is lifted. If you do not pay the fee within six months of your license being automatically suspended, your license will be automatically revoked.

Operation Information

☐ Please check if this is a change of address.

Operation Name:	Operation Number (on your permit):	Telephone No. with Area Code:
CHSI Stanford House Shelter		[redacted]

Operation Address (Street, City, State and ZIP Code):	County:
[redacted]	Cameron

Email Address:
maguilar02@chsmedical.com

RECEIVED JUL 22 2019

Fees

Service Code	Operation Type (check one)	Fee Type (check all that apply)	Amount
529200992	◉ General Residential Operation ○ Child-Placing Agency ○ Independent Foster Home	☑ Application ☑ Initial ☐ Initial Renewal ☑ Non-expiring License Fee ☐ Annual Fee See amounts under the **Fee Definitions** above.	$105.00
529200992	☐ Amendment – increased capacity only; $1 for each additional child: _____ x $1		
529200992	Capacity – Number of children for which you are licensed: 64 x $1 (Only paid with non-expiring license fee or annual renewal)		$64.00
529200988	☑ Background Check Fee	Number of Persons being checked: 2 x $2	$4.00
		Total Amount of Fees Paid:	**$173.00**

THIS IS WATERMARKED PAPER - DO NOT ACCEPT WITHOUT NOTING WATERMARK - HOLD TO LIGHT TO VERIFY WATERMARK

Comprehensive Health Services, LLC
8600 Astronaut Blvd.
Cape Canaveral, FL 32920
321-783-2720

Suntrust Bank
SUNTRUST BANK
65-270/550

000562197

DATE	CONTROL NO.	AMOUNT
07/09/2019	000562197	$173.00

PAY One Hundred Seventy Three And 00/100 Dollars

To The Order Of
TEXAS HEALTH AND HUMAN SERVICES COMMISS
ACCOUNTS RECEIVABLE
PO BOX 149055
AUSTIN, TX 78714-9055
UNITED STATES OF AMERICA

****VOID AFTER 90 DAYS****

Memo:_____

⑈000562197⑈ ⑆055002707⑆ 202131246⑈

Comprehensive Health Services, LLC 562197

Voucher No.	Vendor ID	Invoice Number	Invoice Date	Discount Taken	Net Amount Paid
2730664	G109783	LICENSEFEE2019	07/09/2019	$.00	$173.00
Subtotals				$.00	$173.00
Totals				$.00	$173.00

	Check Notes
2730664	Application Fee: $30 (Sanford House) Initial License Fee: $35 Non-Expiring License Fe

RECEIVED JUN 2 2 2019